08120 08104

Item 21
FilmC171 10-15-54 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 20

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Woodland Beach

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Harwood
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) (Last) AISQUITH

4. DATE OF DEATH (Month) (Day) (Year) Sept. 18 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH: Feby 2-1906
9. AGE last birthday: 49 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (State or foreign country): A A Co Md
12. CITIZEN OF WHAT COUNTRY? N.S.A.

13. FATHER'S NAME: Joseph Nelson Aisquith
14. MOTHER'S MAIDEN NAME: Etha Ellen Dove

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Elizabeth E. Gray Seat Pleasant Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | INTERVAL BETWEEN ONSET AND DEATH

892.9

Immediate cause (a) Carbon monoxide poisoning

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Extensive burns

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) #
21c. (City or town) (County) (State) #

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) # M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR? #

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE William Howitt M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED 9/19/54

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): DATE THEREOF Sept 21-54 | NAME OF CEMETERY OR CREMATORY Mt Calvary | LOCATION (City, town, or county) Greenock (State) Md

DATE REC'D BY LOCAL REG. Sept. 21, 1954 | REGISTRAR'S SIGNATURE Edward Collinson | 24. FUNERAL DIRECTOR John M. Taylor Sons | ADDRESS Annapolis Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16A - 5 - 58

RECEIVED
SEP 27 1954
BUREAU V. S.

MARYLAND 08102

08105

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

M

I

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural- Annapolis
STREET ADDRESS (If rural, give location) Wild Rose Shore

3. NAME OF DECEASED (Type or Print) (First) FANNIE (Middle) (Last) BORO

4. DATE OF DEATH (Month) (Day) (Year) September 17, 1954

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Dec. 14, 1883
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) no
16. SOCIAL SECURITY No. none
17. INFORMANT AND ADDRESS Dr. Alex L. Boro- Son - Same as # 2

4

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Ac. Coronary Infarct — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Thrombosis, rt. hemiplegia — 5 days

(c) Arteriosclerotic Cardio Vascular Disease — yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

0

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☒
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/12, 1954, to 9/17, 1954 that I last saw the deceased alive on Sept. 17, 1954, and that death occurred at 12:30 P.m., from the causes and on the date stated above.

SIGNATURE Maurice Klawans (Degree or title) MD ADDRESS Annapolis Md DATE SIGNED 9/18/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Sept. 19, 54
NAME OF CEMETERY OR CREMATORY Anshe Niesen Cemetery
LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE REC'D BY LOCAL REG. Sept. 18, 1954
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Ball. Hopping and Son ADDRESS Annapolis, Maryland

RECEIVED
SEP 21 19
BUREAU V. S.

MARYLAND 08121

08106

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 214 OAK LANE S.W.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A.A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE
STREET ADDRESS (If rural, give location) 214 OAK LANE S.W.

3. NAME OF DECEASED (Type or Print): (First) CARRIE (Middle) S (Last) CARTER

4. DATE OF DEATH: (Month) SEPT. (Day) 5 (Year) 1954

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, (WIDOWED) DIVORCED, (Specify) WIDOW

8. DATE OF BIRTH: DEC. 16, 1873

9. AGE last birthday: 80 yrs. If under 1 year: Months. Days. If under 24 hrs: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK (RETIRED)

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): BALTIMORE MD

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: GEORGE PENN

14. MOTHER'S MAIDEN NAME: CHARLOTTE E. CHISHOLM

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT AND ADDRESS: MRS. CELESTE SEARS 214 OAK LANE S.W. GLEN BURNIE, MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arthritis - Fractured Left Hip

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1944, to Sept 5, 1954, that I last saw the deceased alive on 9-4, 1954, and that death occurred at 10.20 P m., from the causes and on the date stated above.

SIGNATURE Gilman Neman (Degree or title) ADDRESS Millersville Md DATE SIGNED 9/6/54

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE Sept. 8, 1954
NAME OF CEMETERY OR CREMATORY BALDWIN MEMORIAL
LOCATION (City, town, or county) MILLERSVILLE, (State) MD

DATE REC'D BY LOCAL REG. September 7, 1954
REGISTRAR'S SIGNATURE L. J. De Alba

24. FUNERAL DIRECTOR Jos Dugleton ADDRESS Glen Burnie, Md

RECEIVED
SEP 8 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08107

08103

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

1. PLACE OF DEATH:
COUNTY AA MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, 10
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S.N.H. Annapolis, Md. 50

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY AA
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, 10
STREET ADDRESS (If rural give location) 15 Southgate Ave.,

3. NAME OF DECEASED: (Type or Print) (First) Helen (Middle) (none) (Last) CHEW

4. DATE OF DEATH: (Month) Sept. (Day) 25 (Year) 1954

5. SEX: F

6. COLOR OR RACE: Cauc.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 6/4/12

9. AGE last birthday: 42 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): California

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John T Loughan

14. MOTHER'S MAIDEN NAME: Katherine Willson

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 X

Immediate cause (a) Hypertensive Cardio-vascular Disease — Interval Between Onset And Death: 3 yrs.

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/24, 1954, to 9/25/54, 19....., that I last saw the deceased alive on 9/25, 19....., and that death occurred at 12:05 AM, from the causes and on the date stated above.

SIGNATURE Robert. [signature] (Degree or title) M.D. ADDRESS U.S. Naval Hospital Annapolis Md. DATE SIGNED 9-25-54

23. ~~BURIAL~~, CREMATION, ~~REMOVAL~~ (Specify) DATE THEREOF 9-25-54 NAME OF CEMETERY OR CREMATORY Ft Lincoln LOCATION (City, town, or county) Prince Geo Co (State) Md

DATE REC'D BY LOCAL REGISTRAR Sept. 25, 1954 REGISTRAR'S SIGNATURE [signature] O. Prunch

24. FUNERAL DIRECTOR John M. Taylor Sons ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

VS. A15

RECEIVED
SEP 28 1954
BUREAU V. S.

08104 Item 1, FilmG171 10-15-54 at

08108

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

1. PLACE OF DEATH:
COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
LENGTH OF STAY (in this place) D.O.A.
HOSPITAL OR INSTITUTION OR STREET ADDRESS ANNE ARUNDEL GENERAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MICHIGAN COUNTY WAYNE
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN GROSSE ILE 59X-3
STREET ADDRESS (If rural, give location) 8366 RUCKER ST.

3. NAME OF DECEASED: (Type or Print) (First) JAMES. (Middle) R. (Last) Cole

4. DATE OF DEATH (Month) (Day) (Year) SEPTEMBER 26 1954

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED
8. DATE OF BIRTH: OCT. 30, 1892
9. AGE last birthday: 16th/61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) ELECTRICAL ENGR.
10b. KIND OF BUSINESS OR INDUSTRY: SOCONY VACUMN Co
11. BIRTHPLACE (State or foreign country): HARMANS A.A Co., MD
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: RICHARD STANLEY COLE.
14. MOTHER'S MAIDEN NAME: ANNIE E. FOREMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES (If Yes, give war or dates of service) W.W I
16. SOCIAL SECURITY No.: UNKNOWN
17. INFORMANT & ADDRESS: MRS. IRENE Y. COLE 405 E. MAPLE ROAD LINTHICUM HEIGHTS MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 420.1

Immediate cause (a) Coronary disease — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.,
21c. (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE E. Lin Scott M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 9/26/54

23. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
DATE THEREOF SEPT. 28, 1954
NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY
LOCATION (City, town, or county) (State) BALTIMORE, MD

DATE REC'D BY LOCAL REG. September 28, 1954
REGISTRAR'S SIGNATURE Wm. J French
L. J. DeAlba mnt
24. FUNERAL DIRECTOR R.Y. SINGLETON, ADDRESS GLEN BURNIE, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

RECEIVED
SEP 30 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08165

08122 **CERTIFICATE OF DEATH** Reg. Dist. No. .....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 3mos.15 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 1414 N. Bond Street

3. NAME OF DECEASED: (Type or Print) (First) Theresa (Middle) Matilda (Last) Cole

4. DATE OF DEATH: (Month) 9 (Day) 23 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Separated

8. DATE OF BIRTH: 1902? 1887? 68?

9. AGE last birthday yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY: Private family

11. BIRTHPLACE (State or foreign country): Maryland — Baltimore

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: W Unknown Chas. Cole

14. MOTHER'S MAIDEN NAME: Unknown Henrietta Keys

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Chronic Myocarditis

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Brain Syndrome associated with cerebral arteriosclerosis Known to us since 6/8/54

19A. DATE OF OPERATION: — — — — —

19B. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — — — — — — —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — — — — —

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) — — — — — — — — — — — —

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — — — — — — — M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from .. , 19. , to 9/23., 19 .54 that I last saw the deceased alive on 9/23. ..., 19 54, and that death occurred at 1:30a M, from the causes and on the date stated above.

SIGNATURE Stanley C. Sargeant M. D. ADDRESS Crownsville, Md. DATE SIGNED 9/23/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 9-25-54

NAME OF CEMETERY OR CREMATORY Mt. Auburn

LOCATION (City, town, or county) (State) Balto., Md.

DATE REC'D BY LOCAL REGISTRAR September 25 1954

REGISTRAR'S SIGNATURE R.M.F.

24. FUNERAL DIRECTOR Charles R. Law ADDRESS Balto md

08123

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08110

CERTIFICATE OF DEATH

Reg. Dist. No. 25

Item 1, FilmG170A 9-22-54 et

M

The correct age

Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel Co MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn 25
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE 5020 Brookwood Rd COUNTY A.A. Co
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn - 25 - Md
STREET ADDRESS (If rural, give location) 5020 Brookwood Rd

3. NAME OF DECEASED (Type or Print) (First) EVELYN (Middle) CATHRINE (Last) CONROY

4. DATE OF DEATH (Month) Sept (Day) 3 (Year) 1954

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 7-4-1912

9. AGE last birthday 42 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food manager

10b. KIND OF BUSINESS OR INDUSTRY Restaurant

11. BIRTHPLACE (State or foreign country) Balto Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Matthew Thompson

14. MOTHER'S MAIDEN NAME Margaret Coppernoll

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No. 220-12-8663

17. INFORMANT AND ADDRESS Martin J. Conroy 5020 Brookwood Rd

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) CARCINOMA OF CERVIX

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) With Widespread Metastasis

(c)

INTERVAL BETWEEN ONSET AND DEATH 1 year

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) BALTIMORE 25, (COUNTY) AA (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 31, 1953, to 3 Sept, 1954, that I last saw the deceased alive on 3 Sept, 1954, and that death occurred at 10:05 a.m., from the causes and on the date stated above.

SIGNATURE Benjamin Berdiansky (Degree or title) ADDRESS 5004 Ritchie Highway DATE SIGNED 4 Sep 54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE 9--7--1954
NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery
LOCATION (City, town, or county) 4300 Old Frederick Rd (State) Bal. Md

DATE REC'D BY LOCAL SEP 6 1954
REGISTRAR'S SIGNATURE [illegible] Ida M. Watson

24. FUNERAL DIRECTOR Thomas J. Kenny. Inc. ADDRESS 1600 Hollins St

RECEIVED
SEP 9 1...
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08111

08105

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital Annapolis, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY An.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Severn, Annapolis, Md.
STREET ADDRESS (If rural give location) 214 Gage Road

3. NAME OF DECEASED: (Type or Print) (First) Mildred (Middle) Elizabeth (Last) DI CRISMINO

4. DATE OF DEATH: (Month) September (Day) 23 (Year) 1954

5. SEX: F
6. COLOR OR RACE: Cau.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M
8. DATE OF BIRTH: 11/1/25
9. AGE last birthday: 28 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joel Bates
14. MOTHER'S MAIDEN NAME: Marion Powell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Hospital

18. MEDICAL CERTIFICATION #N853

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Contusion and Hemorrhage of inferior portions of both frontal & temporal lobes of brain — Interval Between Onset And Death 3 days

Immediate cause (a) DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Basil skull fracture #N801 DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street (CITY OR TOWN) North Severn, Annapolis (COUNTY) AA (STATE) Md.
TIME OF INJURY (Month) Sept (Day) 21 (Year) 54 (Hour) 3:00 pm.
INJURY OCCURED While at Work ☐ Not While At Work ☒
HOW DID INJURY OCCUR? Fell from moving auto striking head on pavement

22. I hereby certify that I attended the deceased from 9/21, 1954, to 9/23/, 1954, that I last saw the deceased alive on 9/23, 1954, and that death occurred at 5:50 pm, from the causes and on the date stated above.

SIGNATURE Deane S. Maxey (Degree or title) Canada (Mc) USN ADDRESS U.S.N. Hospital, Annapolis Md. DATE SIGNED 9-24-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept. 27, 1954
NAME OF CEMETERY OR CREMATORY Cathedral Cemetery
LOCATION (City, town, or county) Baltimore, Md. (State)
DATE REC'D BY LOCAL REGISTRAR September 25, 1954
REGISTRAR'S SIGNATURE R.W.

24. FUNERAL DIRECTOR C. Vernon Lemmon ADDRESS 4611 Park Heights Ave., Baltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

08124 **MARYLAND STATE DEPARTMENT OF HEALTH** 08112

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie — LENGTH OF STAY (In this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
HOSPITAL OR INSTITUTION OR STREET ADDRESS RFD # 1	STREET ADDRESS (If rural, give location) RFD # 1

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	Larkin	Dicus	Sept. 10, 1954 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Oct. 5, 1887	66 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ship Construction	Coast Guard	Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William H. Dicus	Lillie Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		Ethel J. Dicus Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Degeneration Cardio Vascular Disease	1 week
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	5 yrs.
	(c) Obesity	—
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	None	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 12-24, 1949, to 9-10, 1954, that I last saw the deceased alive on 9-7, 1954, and that death occurred at 9 A. m., from the causes and on the date stated above.

SIGNATURE James Stowell (Degree or title) ADDRESS Catonsville DATE SIGNED 9-10-54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9/13/54	Cedar Hill	Anne Arundel Co. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-13-54	[signature]	John F. Denny, Inc.	715 Light St. Balto., 30, Md.

08113

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08125

CERTIFICATE OF DEATH

Reg. Dist. No. 28

Items 8,9,F'lmG17- 9-20-54 et

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY: Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville

LENGTH OF STAY (in this place): 3 yrs. 18 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Wicomico

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Nanticoke

STREET ADDRESS (If rural give location): Unknown

3. NAME OF DECEASED: (Type or Print) (First) Lottie (Middle) (Last) Dobson

4. DATE OF DEATH: (Month) 9 (Day) 7 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): /

8. DATE OF BIRTH: 9-25-1892 1891 ?82

9. AGE last birthday: 61 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Undetermined

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis — Interval Between Onset And Death: 7 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b)

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — — — —

19b. MAJOR FINDINGS OF OPERATION — — — —

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — — — —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — —

(CITY OR TOWN) (COUNTY) (STATE) — — — — — — — — — — — —

TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 10/6 ,1952, to 9/7 , 1954, that I last saw the deceased alive on 8/7 , 19.54, and that death occurred at 5:05 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Stephen E. Kramer M.D.

ADDRESS: Crownsville, Md.

DATE SIGNED: 8/7/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 9-11-54

NAME OF CEMETERY OR CREMATORY: Nanticoke Elm

LOCATION (City, town, or county) (State): Nanticoke, Md.

DATE REC'D BY LOCAL REGISTRAR: Sept 8, 1954

REGISTRAR'S SIGNATURE: Katherine M. Joyce Asst

24. FUNERAL DIRECTOR: James E. Caddell

ADDRESS: Easton Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08114

CERTIFICATE OF DEATH

08106

Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arun
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 12 Brewer Ave

3. NAME OF DECEASED: (Type or Print) (First) SARAH (Middle) E (Last) DOVE

4. DATE OF DEATH: (Month) (Day) (Year) Sept. 6, 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 10, 1896

9. AGE last birthday: 58 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS Hours — Min. —

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): West Point, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John A Downer

14. MOTHER'S MAIDEN NAME: Mary Ogden

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ---
(If Yes, give war or dates of service) ---

16. SOCIAL SECURITY NO.: ---

17. INFORMANT & ADDRESS: Mr. R. Edward Dove Husband same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: 1-2 HRS.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease — 10 YRS.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 1954, to 6 Sept 1954, that I last saw the deceased alive on 6 Sept 1954, and that death occurred at 12:20 PM, from the causes and on the date stated above.

SIGNATURE Edward L Beach (Degree or title) MD ADDRESS 4 Southgate Ave Annapolis DATE SIGNED 6 Sept 54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept. 8, 54
NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery
LOCATION (City, town, or county) Annapolis, Maryland (State)

DATE REC'D BY LOCAL REGISTRAR Sept. 7, 1954
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Ben L. Hopping and Son ADDRESS Annapolis, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08115

03126

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH. COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 4yrs.4mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 1530 McElderry Street

3. NAME OF DECEASED: (Type or Print) (First) Lula (Middle) (Last) Flood
4. DATE OF DEATH: (Month) 9 (Day) 20 (Year) 1954
5. SEX: F
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married
8. DATE OF BIRTH: 1890?
9. AGE last birthday 64? yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Andrew Stewart
14. MOTHER'S MAIDEN NAME: Elizar (Last name unknown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1

IMMEDIATE CAUSE (A) Chronic Myocarditis — Known to us since adm. 5/17/50

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized Arteriosclerosis " "

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senility " "

19A. DATE OF OPERATION: - - - -
19B. MAJOR FINDINGS OF OPERATION -
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - - - - - -
21C WHERE DID INJURY OCCUR? (City or town) (County) (State) - - - - - - - - - - - -
21D TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - - - - - M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? - - - - - - - - - - - -

22. I hereby certify that I attended the deceased from 10/6, 1952, to 9/20, 1954, that I last saw the deceased alive on 9/20, 1954 and that death occurred at 5:15 P.M. from the causes and on the date stated above.

SIGNATURE Stephen E. Kramer M.D. ADDRESS Crownsville, Md. DATE SIGNED 9/21/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF Sep 24 NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery LOCATION (City, town, or county) Cedar Hill Md. (State)

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR A. Halsted 9/18/54 ADDRESS Bill Ave.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-

08127

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08116

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY [illegible] MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural
LENGTH OF STAY (in this place) 35 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE [illegible] COUNTY Md
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLENBURNIE, MD.
STREET ADDRESS (If rural, give location) 209 ANNAPOLIS BLVD

3. NAME OF DECEASED (Type or Print) (First) AGNES (Middle) — (Last) FORTSCH
4. DATE OF DEATH (Month) 9 (Day) 9 (Year) 1954
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) SINGLE
8. DATE OF BIRTH 9-7-1881
9. AGE last birthday 73 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY HOLY TRINITY CHURCH
11. BIRTHPLACE (State or foreign country) GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A. YES
13. FATHER'S NAME GEORGE FORTSCH
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of [illegible])
16. SOCIAL SECURITY NO. 215-07-4065
17. INFORMANT AND ADDRESS [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Gastro-Intestinal Hemorrhage	IMMEDIATE
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) CANCER OF STOMACH	8 MOS.
	(c) —	—

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) (COUNTY) (STATE) — —
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 1-30, 1954, to 9-9, 1954, that I last saw the deceased alive on 9-8, 1954 and that death occurred at 9:45 P m., from the causes and on the date stated above.

SIGNATURE Leon C. Perry, (Degree or title) M.D. ADDRESS 201 B+A BLVD, GLEN BURNIE, MD. DATE SIGNED 9-10-54

23. BURIAL, CREMATION REMOVAL (Specify) [illegible]
DATE THEREOF Sept 13-54
NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery
LOCATION (City, town, or county) Baltimore Co (State) Md

DATE REC'D BY LOCAL REG. September 11, 1954
REGISTRAR'S SIGNATURE L. J. D'Alba
24. FUNERAL DIRECTOR Bernard G. Funk ADDRESS Glen Burnie, Md

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08117

MARYLAND 08107

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

MARGIN RESERVED FOR BINDING

I

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 103 Ridgley Ave

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) F. (Last) Fruengel Sr.
4. DATE OF DEATH (Month) 9 (Day) 30 (Year) 1954

5. SEX Male
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH July 4th 1883
9. AGE last birthday 71 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker
10b. KIND OF BUSINESS OR INDUSTRY Baker
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Virginia Fruengel Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Failure — 2 mos.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Cardio Vascular disease — yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chr. Nephritis — yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 12, 1953, to 9/30, 1954, that I last saw the deceased alive on 9/28, 1954, and that death occurred at 9.30 P m., from the causes and on the date stated above.

SIGNATURE Maurice Klawans Md (Degree or title) ADDRESS Annapolis, Md DATE SIGNED 10/2/54

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE 10-3-54 NAME OF CEMETERY OR CREMATORY Hillcrest LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Oct. 3, 1954 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M Taylor Sons ADDRESS Annapolis Md

08128

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08118

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital, Annapolis,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis, Maryland
STREET ADDRESS (If rural give location): 139 Spaview Avenue

3. NAME OF DECEASED: (Type or Print) (First) CONRAD (Middle) SMITH (Last) GAW Md.

4. DATE OF DEATH: (Month) Sept. (Day) 6 (Year) 19 54

5. SEX: M

6. COLOR OR RACE: Caucasian

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: 3 June 1896

9. AGE last birthday: 58 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): USN

10b. KIND OF BUSINESS OR INDUSTRY: Ret.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Annie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes
(If Yes, give war or dates of service): 1912-1932

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinomatosis of: Lungs - Liver - Spleen - DUE TO — Interval Between Onset And Death: Undetermined

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Pancreas - Bones #199 DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-6-54, 19.. to 9-6, 19.54, that I last saw the deceased alive on 9-6, 1954, and that death occurred at 1430 ..., from the causes and on the date stated above.

SIGNATURE (Degree or title): Parker H. Lee Jr. Lt. MC USNR
ADDRESS: U.S. NAVAL HOSPITAL
DATE SIGNED: 6 Sept 1954

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF: 9-9-54 — NAME OF CEMETERY OR CREMATORY: National Cem — LOCATION (City, town, or county) (State): Annapolis Md

DATE REC'D BY LOCAL REGISTRAR: Sept. 8, 1954

REGISTRAR'S SIGNATURE: J. O'Donnell

24. FUNERAL DIRECTOR: John M. Sayler Sons — ADDRESS: Annapolis Md.

VS. A15

SEP 9 19
BUREAU V. S.

08129 08119

MARYLAND STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park (rural) LENGTH OF STAY (in this place) 26 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Jumper Hob Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park (rural)
STREET ADDRESS (If rural, give location) Jumper Hob Road

3. NAME OF DECEASED (Type or Print) (First) Samuel (Middle) L (Last) Halfpenny

4. DATE OF DEATH (Month) September (Day) 13, (Year) 1954

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH May 29, 1883

9. AGE last birthday 71 yrs. If under 1 year: Months, Days; If under 24 hrs: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stonehaker (retired)

10b. KIND OF BUSINESS OR INDUSTRY U.S.C.G. Yard Sparrows Point

11. BIRTHPLACE (State or foreign country) Belair, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Halfpenny

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If year, give war or dates of service)

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT AND ADDRESS Mrs. Ruth C. Hoskins Jumper Hob Road Severna Park (rural)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral vascular accident — 2 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1953, to Sept., 1954, that I last saw the deceased alive on 13 Sept., 1954, and that death occurred at 11 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Bruce W. Trestin MD [illegible] 15 Sept 54

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Sept. 16 1954

NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery

LOCATION (City, town, or county) (State) Glen Burnie, Md.

DATE REC'D BY LOCAL REG. September 16, 1954

REGISTRAR'S SIGNATURE L. J. D'Alba

24. FUNERAL DIRECTOR W. V. Singleton ADDRESS Glen Burnie, Md.

08120

MARYLAND 03108

STATE DEPARTMETT OF HEALTH

T Book

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.
STREET ADDRESS (If rural, give location) 1139 Eastport Terrace

3. NAME OF DECEASED (Type or Print) (First) George (Middle) V. (Last) Hallock

4. DATE OF DEATH (Month) 9- (Day) 20- (Year) 1954

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 5-29-1882
9. AGE last birthday 72 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Carpenter (House)
11. BIRTHPLACE (State or foreign country) Shadyside Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Joshua T. Hallock
14. MOTHER'S MAIDEN NAME Charlotte Atwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Margaret E. Hallock (2)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Uremia	5 days
Antecedent cause(s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Nephrosclerosis	unknown
	(c)	Diabetes Mellitus	3 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Uremic Pericarditis unknown

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-10, 1954, to 9-20, 1954, that I last saw the deceased alive on 9-20, 1954, and that death occurred at 2:00 m., from the causes and on the date stated above.

SIGNATURE Edward S Beck (Degree or title) M.D. ADDRESS 41 Southgate Ave DATE SIGNED 9-22-54

23. BURIAL, CREMATION REMOVAL (Specify) DATE 9-23-54 NAME OF CEMETERY OR CREMATORY Quaker Burial Grounds LOCATION (City, town, or county) Galesville (State) Md

DATE REC'D BY LOCAL REG. Sept. 23, 1954 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Sons ADDRESS Annapolis Md

MARGIN RESERVED FOR BINDING

MARYLAND 08130

08121

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 407 Second ave. S.W.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie
STREET ADDRESS (If rural, give location): 407 Second ave. S.W.

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Mitchell (Last) Hardester

4. DATE OF DEATH: (Month) 9 (Day) 11 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: December 5, 1881

9. AGE last birthday: 72 yrs. If under 1 year: Months. If under 24 hrs: Days. If under 24 hrs: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (Ret)

10b. KIND OF BUSINESS OR INDUSTRY: Self-Contractor

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Christopher Columbus Hardester

14. MOTHER'S MAIDEN NAME: Anna M. Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) W.W.I

16. SOCIAL SECURITY No. 217-01-9941

17. INFORMANT AND ADDRESS: Mrs. Anna M. Hardester 407 Second ave. SW Glen Burnie, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lobar pneumonia, bilateral

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma, Colon

(c)

INTERVAL BETWEEN ONSET AND DEATH: 2 dys.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9-12-54

19b. MAJOR FINDINGS OF OPERATION: Carcinoma colon & metastasis

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-1-54, to 9-10-54, that I last saw the deceased alive on 9-10-54, and that death occurred at 7:25 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. B. Mackenzie M.D. ADDRESS Glen Burnie, Md. DATE SIGNED 9-11-54.

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE Sept. 13 1954 NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery LOCATION (City, town, or county) Glen Burnie Md. (State)

DATE REC'D BY LOCAL REG. September 14 1954 REGISTRAR'S SIGNATURE L. D'Alba

24. FUNERAL DIRECTOR R. E. Higgins ADDRESS Glen Burnie, Md.

MARGIN RESERVED FOR BINDING

MARYLAND 08131 08122

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riva
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS River View Nurning Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
STREET ADDRESS (If rural, give location) Market Space

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) JOHN HAUSNER

4. DATE OF DEATH (Month) (Day) (Year) SEPT. 28, 1954 19

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH June 13, 1884
9. AGE last birthday 70 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cobler
10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV.
11. BIRTHPLACE (State or foreign country) Check
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) no
16. SOCIAL SECURITY No. none
17. INFORMANT AND ADDRESS James S. Williams; Harness Creek, Annapolis, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage with — 1 year

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) left hemiplegia

(c) Arteriosclerotic Heart Disease — Several Years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1953, to Sept 28, 1954, that I last saw the deceased alive on Sept 28, 1954, and that death occurred at 11^{30} P m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 10-1-54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE October 1, 54
NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery
LOCATION (City, town, or county) (State) Annapolis, Maryland

DATE REC'D BY LOCAL REG. Oct. 1, 1954
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR ADDRESS Ben L. Hopping and Son Annapolis, Md.

OCT 4 1954

V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08132

CERTIFICATE OF DEATH

08123

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY A.A. MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BK.

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 5215 Kramme Av.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BK.

STREET ADDRESS (If rural give location) 5215 Kramme Ave

3. NAME OF DECEASED: (Type or Print) (First) Ralph (Middle) E. (Last) Henry

4. DATE OF DEATH: (Month) 9. (Day) 17 (Year) 1954

5. SEX: M.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.

8. DATE OF BIRTH: 3.23.12

9. AGE last birthday: 42 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Carp.

10b. KIND OF BUSINESS OR INDUSTRY: Jun Co.

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ira M.

14. MOTHER'S MAIDEN NAME: Clara McNaughton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 185-07-5493

17. INFORMANT & ADDRESS: F-S.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cancer of the lung

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/7/1954, to 9/17/1954, that I last saw the deceased alive on 9/16, 1954, and that death occurred at 9 45 AM, from the causes and on the date stated above.

SIGNATURE Paul H. Armino (Degree or title) M.D. ADDRESS 5004 Ritchie Hgw. DATE SIGNED 9/20/54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 9-20-54 NAME OF CEMETERY OR CREMATORY Prospect Hill LOCATION (City, town, or county) (State) Balto.

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Wm. L. McCurdy ADDRESS 130 E. Fort Ave.

20 PAID

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

Dr. Paul Amigo.
Nov 5/16 08

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08124

08133 CERTIFICATE OF DEATH Reg. Dist. No. 29

1. PLACE OF DEATH: COUNTY HOME P.A.Co. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MARLEY MARYLAND LENGTH OF STAY (in this place) Life HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt. 1 - Box 98 Glen Burnie Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie Md. STREET ADDRESS (If rural give location) Rt 1 - Box 98.

3. NAME OF DECEASED: (Type or Print) (First) HARLOW (Middle) CROSBY (Last) HOWARD

4. DATE OF DEATH: (Month) Sept. (Day) 8 (Year) 1954

5. SEX: M

6. COLOR OR RACE: Col

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S

8. DATE OF BIRTH: April 13 1936

9. AGE last birthday: 18 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: None

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country) MARLEY Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: KING LEE HOWARD

14. MOTHER'S MAIDEN NAME: SARAH THERESA Boston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: CLARENCE R. HOWARD SAME

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute pulmonary edema DUE TO — Interval Between Onset And Death: 2 hours

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Bronchial asthma DUE TO — 12 years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 5, 1950, to Sept. 8, 1954, that I last saw the deceased alive on Sept 8, 1954, and that death occurred at 8:05 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

R. M. McLaughlin M.D. Pasadena, Md. Sept. 8, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 9/11/54 NAME OF CEMETERY OR CREMATORY Mt Calvery Cem. LOCATION (City, town, or county) (State) Brooklyn Md.

DATE REC'D BY LOCAL REGISTRAR 9/10/54 REGISTRAR'S SIGNATURE A W Hedrick JCL

24. FUNERAL DIRECTOR Elroy O. Wilson ADDRESS 1000 Prantley Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct. are is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND 08134 08125 STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riva
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riva (Sylvan Shores)
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) WILLIAM (Middle) LEE (Last) Hughes
4. DATE OF DEATH (Month) Sept. (Day) 8 (Year) 1954
5. SEX MALE
6. COLOR OR RACE WHITE
7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) Married
8. DATE OF BIRTH Aug 7, 1892
9. AGE last birthday 62 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired-Contractor
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Joseph Hughes
14. MOTHER'S MAIDEN NAME Gross
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) WW I
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Mrs. Estelle O. Hughes Same as #2.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

163X

Immediate cause (a) Carcinoma of lung (W) c

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) generalized metastases — 9 mos.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1948, to Sept 8, 1954, that I last saw the deceased alive on Sept. 7, 1954, and that death occurred at 6 35 a m., from the causes and on the date stated above.

SIGNATURE S. Borssuch (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 9/8/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 9-11-54
NAME OF CEMETERY OR CREMATORY Rockville Union Cem
LOCATION (City, town, or county) Montgomery Co. (State) Md.

DATE REC'D BY LOCAL REG. Sept. 8, 1954
REGISTRAR'S SIGNATURE Edward Collinson
24. FUNERAL DIRECTOR Robert A. Humphrey sp
ADDRESS Bethesda Md.

MARGIN RESERVED FOR BINDING

I

08126

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08135

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY AA
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Drusella (Middle) (Last) Isaacs
4. DATE OF DEATH: (Month) (Day) (Year) 9 - 22 1954

5. SEX: Fe
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1894
9. AGE last birthday: 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Philip Brown
14. MOTHER'S MAIDEN NAME: Virginia Anderson

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no
16. SOCIAL SECURITY No.: none
17. INFORMANT & ADDRESS: Richard Isaac, Edgewater Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 151X (a) Carcinoma of the stomach — Interval Between Onset And Death at least 6 mos.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition

19a. DATE OF OPERATION: April 1954
19b. MAJOR FINDINGS OF OPERATION Record from J.H.H not obtained
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-24, 1954, to 9-22, 1954, that I last saw the deceased alive on 9-22, 1954, and that death occurred at 6 a.m., from the causes and on the date stated above.

SIGNATURE Chas W Allen (Degree or title) M.D. ADDRESS 10 Carroll DATE SIGNED 9-23-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Sept 25, 1954 NAME OF CEMETERY OR CREMATORY Chews LOCATION (City, town, or county) West River, Md (State)

DATE REC'D BY LOCAL REGISTRAR Sept 25, 1954 REGISTRAR'S SIGNATURE Edward Collinson
24. FUNERAL DIRECTOR T A Hardesty & Son, Galesville Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

SEP 28 1954
BUREAU U. S.

08109

08127

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A. A.
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 40 Pinkney St.

3. NAME OF DECEASED: (Type or Print) (First) Baby (Middle) Boy (Last) Jacobs.
4. DATE OF DEATH (Month) 9 (Day) 28 (Year) 1954.

5. SEX: Male
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S.
8. DATE OF BIRTH: 9-28-54
9. AGE last birthday: yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Annapolis
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John E. Jacobs
14. MOTHER'S MAIDEN NAME: Mary Sembly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: John E. Jacobs - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
Immediate cause (a) Prematurity
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 1 hr. 28 Mins

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.,
21c. (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM ☐
DATE SIGNED 9/28/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 9-29-54
NAME OF CEMETERY OR CREMATORY Brewer Hill
LOCATION (City, town, or county) Annapolis, Md. (State)

DATE REC'D BY LOCAL REG. Sept. 29, 1954
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR William Reese, III - 108 N. Main Street Annapolis, Md.
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

OCT 1

08128

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08136 **CERTIFICATE OF DEATH** Reg. Dist. No. 27

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade
LENGTH OF STAY (In this place) -
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
STREET ADDRESS (If rural give location) 407 Magnolia Road

3. NAME OF DECEASED: (Type or Print) (First) Elizabeth (Middle) Marie (Last) Jordan

4. DATE OF DEATH (Month) (Day) (Year) September 22 1954

5. SEX Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 22 Sept. 54

9. AGE last birthday: 0 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min. 27

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10B. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Samuel Jordan

14. MOTHER'S MAIDEN NAME: Sara Alice Spanagel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) -

16. SOCIAL SECURITY NO. -

17. INFORMANT & ADDRESS: Mother 407 Magnolia Road, Glen Burnie, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 27 minutes

776X

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) -

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) -

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. -

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from 22 Sept, 1954, to 22 Sept, 1954, that I last saw the deceased alive on 22 Sept, 1954, and that death occurred at 0430 M, from the causes and on the date stated above.

SIGNATURE [signature] ADDRESS DATE SIGNED

ALAN FRIEDMAN 1ST LT MC M.D. USAH, Ft. Meade, Md. 22 Sept 54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 25 Sept 54 — NAME OF CEMETERY OR CREMATORY Post Cemetery — LOCATION (City, town, or county) (State) Fort GG Meade, Maryland

DATE REC'D BY LOCAL REGISTRAR 23 September 54 — REGISTRAR'S SIGNATURE [signature] — 24. FUNERAL DIRECTOR CHAPLAIN RITTER — ADDRESS Ft GG Meade, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08129

08137

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1 PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Howard
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage
STREET ADDRESS (If rural give location) Commercial Street

3. NAME OF DECEASED: (Type or Print) (First) Isaac (Middle) James (Last) Knisley
4. DATE OF DEATH: (Month) September (Day) 23 (Year) 1954
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married
8. DATE OF BIRTH: April 1899
9. AGE last birthday 55 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Civil Service
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Edward Knisley
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) Unknown
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT & ADDRESS: Wife, Commercial Street, Savage, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary occlusion, acute — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Cardiorespiratory failure — 1240

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: -
19B. MAJOR FINDINGS OF OPERATION -
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) -
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) -
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. -
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from 12 Noon 23 Sept 1954, to 1250 23 Sept 1954, that I last saw the deceased alive on 23 Sept. 1954, and that death occurred at 1250 M, from the causes and on the date stated above.

SIGNATURE Delma W Caldwell
DELMA W. CALDWELL, MAJOR, MC M.D. ADDRESS Ft. Geo. G. Meade, Md. DATE SIGNED 23 Sept 54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Unknown
NAME OF CEMETERY OR CREMATORY Savage Cemetery
LOCATION (City, town, or county) (State) Savage, Md.

DATE REC'D BY LOCAL REGISTRAR 23 Sept 54
REGISTRAR'S SIGNATURE HARRY CARLSON, OJG USA
24. FUNERAL DIRECTOR Donaldson
ADDRESS Laurel, Md.

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I MARGIN RESERVED FOR BINDING

08138

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08130 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 28

1. PLACE OF DEATH: COUNTY A.A.Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 7yrs 1mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Howard
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Highland
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Lilian (Middle) (Last) Kosh

4. DATE OF DEATH (Month) 9 (Day) 6 (Year) 1954

5. SEX: F | 6. COLOR OR RACE: C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S | 8. DATE OF BIRTH: 1-25-1923 | 9. AGE last birthday: 31 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): NONE | 10b. KIND OF BUSINESS OR INDUSTRY: None | 11. BIRTHPLACE (State or foreign country): Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Kosh | 14. MOTHER'S MAIDEN NAME: Un Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: None | 17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) DUE TO: Acute Pulmonary Oedema — Interval Between Onset and Death: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | 21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 9/9/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF 9-10-54 | NAME OF CEMETERY OR CREMATORY Hopkins Chapel | LOCATION (City, town, or county) Simpsonville (State)

DATE REC'D BY LOCAL REG. 9-8-54 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR E.C. Higinbotham | ADDRESS Ellicott City Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

SEP 1(

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08131

08139

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY A.A. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BK. LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5/03 Pope St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY AA.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BK.
STREET ADDRESS (If rural give location) 5/03 Pope St.

3. NAME OF DECEASED: (Type or Print) (First) Madeline (Middle) E. (Last) Landwehr
4. DATE OF DEATH: (Month) (Day) (Year) 9.30 1954

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.
8. DATE OF BIRTH: 9.1.01
9. AGE last birthday: 53 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country) Balto.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Geo. R. Bennett
14. MOTHER'S MAIDEN NAME: Margaret Fleagle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Family - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac insuffic DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Cancer of the stomach DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-1, 1954, to 9-30, 1954, that I last saw the deceased alive on 9-29, 1954, and that death occurred at , from the causes and on the date stated above.

SIGNATURE (Degree or title) Eugene Schultz ADDRESS 3904 Stevens DATE SIGNED 10-1-54

23. BURIAL, CREMATION, REMOVAL (Specify) J.S. DATE THEREOF 10.4.54 NAME OF CEMETERY OR CREMATORY Cedar Hill LOCATION (City, town, or county) Balto. (State)

DATE REC'D BY LOCAL REGISTRAR Oct. 2 1954 REGISTRAR'S SIGNATURE R.W.

24. FUNERAL DIRECTOR Jos. L. de Cuney ADDRESS 130 E. Fort Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Mr. Basil

MARYLAND 08110

08132

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

ITEM 8 - film G175 1-5-55 L

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. Gen. Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Delaware COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dover
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) John (Middle) (Last) Mavrides

4. DATE OF DEATH (Month) Sept. (Day) 14 (Year) 1954

5. SEX Male

6. COLOR OR RACE White

7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH June 6, 1884

9. AGE last birthday 70 yrs. If under 1 year: Months, Days. If under 24 hrs: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Owner

10b. KIND OF BUSINESS OR INDUSTRY Restaurant

11. BIRTHPLACE (State or foreign country) Turkey

12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME UNK

14. MOTHER'S MAIDEN NAME UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Helen Mavrides, Dover, Delaware

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage with

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Left Hemiplegia

(c) Arteriosclerotic Heart Disease

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: 3 days; Unknown

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 12, 1954, to Sept 14, 1954, that I last saw the deceased alive on Sept 14, 1954, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

SIGNATURE George C. Basil (Degree or title) M D ADDRESS Annapolis Md DATE SIGNED 9-16-54

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE 9-16-1954 NAME OF CEMETERY OR CREMATORY St. Margarets LOCATION (City, town, or county) Anne Arundel (State) Md.

DATE REC'D BY LOCAL REG Sept. 16, 1954 REGISTRAR'S SIGNATURE [signature] - O. Brunch

24. FUNERAL DIRECTOR John M. Taylor & Sons ADDRESS Annapolis, Md.

REC'D
SEP 20
BUREAU V. S

(M)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08140 MARYLAND STATE DEPARTMENT OF HEALTH 08133

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Items 8,9,FilmG172 10-25-54 et

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harmans — LENGTH OF STAY (in this place) 10 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Riggs Road.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE — COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Ersaline Augusta Matthews

4. DATE OF DEATH (Month) (Day) (Year) Sept. 26 1954

5. SEX F.

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 4/16/1859 1868

9. AGE last birthday 86 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible]

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Howard County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME [illegible]

14. MOTHER'S MAIDEN NAME FLAVOLA - HAWKINS.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS Mrs. [illegible] (daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) [illegible] sclerosis — INTERVAL BETWEEN ONSET AND DEATH [illegible]

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy , Inspection ✗ Inquiry ✗ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ✗, accident , suicide , homicide , undetermined .*

SIGNATURE [illegible] M.D. — (Degree or title) Deputy Medical examiner — ADDRESS Glen Burnie Md. — DATE SIGNED 9/26/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 9-29-54 — NAME OF CEMETERY OR CREMATORY St. [illegible] — LOCATION (City, town, or county) (State) Harmans A.A. Co. Md

DATE REC'D BY LOCAL REG. 9/28/54 — REGISTRAR'S SIGNATURE [illegible] Deputy — 24. FUNERAL DIRECTOR Mrs. Frances A. Henslee [illegible] — ADDRESS [illegible]

(1)

08111 **MARYLAND STATE DEPARTMENT OF HEALTH** 08134

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS 22 Washington Street (W)	STREET ADDRESS (If rural, give location) 22 Washington Street (W)

3. NAME OF DECEASED (Type or Print) (First) Catherine (Middle) Price (Last) Myers				4. DATE OF DEATH (Month) (Day) (Year) 9/21/1954 19	
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 12/31/1899	9. AGE last birthday 54 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic (Maid)		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Edward Price			14. MOTHER'S MAIDEN NAME Menervia Stewart		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Menervis Brown-22 Washington Street Annapolis, Md.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Broncho-Pneumonia	6 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Hemorrhage due to	10 days
	(c) Arterio sclerotic Hypertensive Cardio Vascular disease	1 year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 6, 1954, to Sept 21, 1954, that I last saw the deceased alive on Sept 21, 1954, and that death occurred at 10:30 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
R. L. Richardson	MD	Annapolis, Md.	9/28/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 9/24/1954	NAME OF CEMETERY OR CREMATORY Greer Hill Cemetery	LOCATION (City, town, or county) West St. Annapolis, Md. (State)
DATE REC'D BY LOCAL REG. Sept. 23, 1954	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR Ethel L. Hicks-45 Northwest St. Annapolis Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The [redacted]ct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08135

08141 **CERTIFICATE OF DEATH** Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater
LENGTH OF STAY (in this place) 4 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Samuel (Middle) (Last) Neal
4. DATE OF DEATH: (Month) Sept. (Day) 11 (Year) 1954
5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Dec. 30 1876
9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY: Tobacco
11. BIRTHPLACE (State or foreign country): McKrendree, Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Richard Neal
14. MOTHER'S MAIDEN NAME: Charlotte Chambers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: Mima Neal, Edgewater, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 445X (A) Arteriosclerotic Hypertension

ANTECEDENT CAUSE (B) DUE TO Cardiovascular disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH: 2 Years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1952, to Sept 11, 1954, that I last saw the deceased alive on Sept 11, 1954, and that death occurred at 10:00 AM, from the causes and on the date stated above.

SIGNATURE: R. Richardson ADDRESS: Annapolis, Md DATE SIGNED: 9/11/54 M. D.

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Sept 14, 1954
NAME OF CEMETERY OR CREMATORY: Chews
LOCATION (City, town, or county) (State): West River, Md.

DATE REC'D BY LOCAL REGISTRAR: Sept. 13, 1954
REGISTRAR'S SIGNATURE: [signature]
24. FUNERAL DIRECTOR: T. A. Hardesty & Son, Galesville, Md. ADDRESS

VS. A15—10

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08136

MARYLAND 08112

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

M

I

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Arne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
STREET ADDRESS (If rural, give location) Defence Highway

3. NAME OF DECEASED (Type or Print) (First) ELIZABETH (Middle) M (Last) NICHOLS

4. DATE OF DEATH (Month) (Day) (Year) September 11 1954

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Nov. 14, 1904

9. AGE last birthday 49 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10b. KIND OF BUSINESS OR INDUSTRY own home

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---- (If year, give war or dates of service) ----

16. SOCIAL SECURITY NO. none

17. INFORMANT AND ADDRESS Mrs. Catherine M. Spencer- Daughter-Annapolis, M 1117 Monroe

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Vascular — 4 years

(c) Disease — 4 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to Sept 11, 1954 that I last saw the deceased alive on Sept 11, 1954 and that death occurred at 11.30 a.m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M D ADDRESS Annapolis Md DATE SIGNED 9-13-54

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Sept. 14, 54

NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery

LOCATION (City, town, or county) (State) Annapolis, Maryland

DATE REC'D BY LOCAL REG. Sept. 13, 1954

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Ben L. Hopping and Son ADDRESS Annapolis, Md.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08137

08142 CERTIFICATE OF DEATH Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Water Oak Point

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena
STREET ADDRESS (If rural give location) Water Oak Point

3. NAME OF DECEASED: (Type or Print) (First) Carrie (Middle) F. (Last) O'Hara

4. DATE OF DEATH: (Month) September (Day) 13, (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: April 1, 1873

9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Carter

14. MOTHER'S MAIDEN NAME: Marietta Lemmon

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Marietta Cushing, Pasadena, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

Immediate cause (a) Acute bronchopneumonia 4 weeks

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

CERTIFICATION APPROVED BY Willis Ward M. D. CHIEF OR ASST. MEDICAL EXAMINER.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture of left hip 5 months

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) Accident

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home

(CITY OR TOWN) Pasadena (COUNTY) Anne Arundel (STATE) Md.

TIME OF INJURY (Month) June (Day) 16, (Year) 1954 (Hour) 6:15 p. m.

INJURY OCCURED While at Work ☐ Not While At Work ☑

HOW DID INJURY OCCUR? Fell in kitchen getting up from table

22. I hereby certify that I attended the deceased from April 26, 1954, to Sept. 13, 1954, that I last saw the deceased alive on Sept. 13, 1954, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

SIGNATURE R. M. McLaughlin (Degree or title) M.D. ADDRESS Pasadena, Md. DATE SIGNED September 15, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Entombment DATE THEREOF Sept. 17, 1954 NAME OF CEMETERY OR CREMATORY Mt. Olivet LOCATION (City, town, or county) Washington, D. C. (State)

DATE REC'D BY LOCAL REGISTRAR 9-15-54 REGISTRAR'S SIGNATURE H. W. Cadwal

24. FUNERAL DIRECTOR Horace F. Burgee ADDRESS Burgee Funeral Home 3631 Falls Road

VS. A15

Approved Sept 15 subject to further investigation by Deputy M.E.

WCL

08143

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 08138

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY A.A.CO. MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) X
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Ind COUNTY A. A.
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Conway A.A.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) (Last) Pindell

4. DATE OF DEATH (Month) Sept (Day) 12 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: June 1926

9. AGE last birthday: 28 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Davidsonville A.A.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew Pindell

14. MOTHER'S MAIDEN NAME: Margrett Bias

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No:

17. INFORMANT'S ADDRESS: Andrew Pindell Gambrills, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Fracture Skull - Basilar — Interval between onset and death: Sudden

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Fracture mandible (R.)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Highway

21c. (City or town) (County) A.A.Co (State) MD

21d. TIME (Month, (Day) (Year) (Hour) OF INJURY Sept 12 54 ? M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☑

21f. HOW DID INJURY OCCUR? Struck by Auto

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE C. Pennington M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☑

DATE SIGNED 9/12/54.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Sept 17 1954

NAME OF CEMETERY OR CREMATORY Mt Tabor

LOCATION (City, town, or county) Churchfield A.A. (State) Md

DATE REC'D BY LOCAL REG. Sept. 14, 1954

REGISTRAR'S SIGNATURE H. C. Branch

24. FUNERAL DIRECTOR J. B. Johnson ADDRESS Annapolis

SEP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08139

08113 # CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY A. A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
STREET ADDRESS (If rural give location) 61 Spa Road

3. NAME OF DECEASED (Type or Print) (First) London (Middle) (Last) Pinkney

4. DATE OF DEATH (Month) 9 (Day) 1 (Year) 1954

5. SEX male female | 6. COLOR OR RACE Negro | 7. SINGLE MARRIED WIDOWED, DIVORCED. (Specify) M | 8. DATE OF BIRTH 7-9-1903 | 9. AGE last birthday 51 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter | 10B. KIND OF BUSINESS OR INDUSTRY. Hotel | 11. BIRTHPLACE (State or foreign country): Annapolis, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME. Walter Pinkney | 14. MOTHER'S MAIDEN NAME: Alice Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. 216-14-3971 | 17. INFORMANT & ADDRESS. Mrs Rozelda Perritt

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Pulmonary Tuberculosis ?

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cirrhosis of Liver ?

19A. DATE OF OPERATION: — | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — M | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/29, 1954 to 9/1, 1954, that I last saw the deceased alive on 8/31, 1954, and that death occurred at 6:17 M, from the causes and on the date stated above.
SIGNATURE Frank M. Shipley M. D. ADDRESS Annapolis DATE SIGNED 9/1/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 9-4-54 | NAME OF CEMETERY OR CREMATORY Brewers Hill | LOCATION (City, town, or county) (State) Annapolis, Md.

DATE REC'D BY LOCAL REGISTRAR 9-2-54 | REGISTRAR'S SIGNATURE A.W. Hedrick Deputy | 24. FUNERAL DIRECTOR William Reese II | ADDRESS 109 W. Wash. St. Annapolis Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Keese

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08144

CERTIFICATE OF DEATH

Reg. Dist. No. 08140

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 14 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 911 W. Franklin Street

3. NAME OF DECEASED: (Type or Print) (First) Noah (Middle) (Last) Richardson

4. DATE OF DEATH: (Month) 9 (Day) 17 (Year) 1954

5. SEX: M
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 10/22/88
9. AGE last birthday 65 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter
10B KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Samuel Richardson
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: Known to us since 9/3/54

ANTECEDENT CAUSE (S) DUE TO (B) Generalized Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cerebral Arteriosclerosis

19A. DATE OF OPERATION: - - - -
19B. MAJOR FINDINGS OF OPERATION -
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - - - M.
21E INJURY OCCURRED While at work [ ] Not while at work [ ]
21F. HOW DID INJURY OCCUR? - - - - - - - - - - - - - - - - - -

22. I hereby certify that I attended the deceased from 9/3, 1954, to 9/17, 1954, that I last saw the deceased alive on 9/17, 1954, and that death occurred at 12:20 a.m. from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS Crownsville, Md. DATE SIGNED 9/17/54

23 BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 9-22-54
NAME OF CEMETERY OR CREMATORY Mt. Auburn
LOCATION (City, town, or county) Balto. City (State) Md.

DATE REC'D BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Walter B. Springs ADDRESS 916 Penna. Ave.

VS. A15—10

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND 08114

08141

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 9, FilmG172 10-25-54 et

1. PLACE OF DEATH: COUNTY: Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: A. A. Co. General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severna Park
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) LILLIAN (Middle) M. (Last) RUSSELL

4. DATE OF DEATH: (Month) Sept. (Day) 17 (Year) 1954

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: Aug. 20, 1904
9. AGE last birthday: 50 54 yrs. If under 1 year: Months Days If under 24 hrs: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10b. KIND OF BUSINESS OR INDUSTRY: Att'y.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Mitchell
14. MOTHER'S MAIDEN NAME: Patricia ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: Mr. Cecil H. Russell-Severna Park, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Laennec's Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio-vascular disease — 5 yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1952, to Sept., 1954, that I last saw the deceased alive on Sept. 17, 1954, and that death occurred at 2:45 P.m., from the causes and on the date stated above.

SIGNATURE: [illegible] (Degree or title): M.D. ADDRESS: [illegible] DATE SIGNED: Sept 17, 1954

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 9/22/54
NAME OF CEMETERY OR CREMATORY: Lorraine Cem.
LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE REC'D BY LOCAL REG.: Sept 21, 1954
REGISTRAR'S SIGNATURE: A. M. Hedrick mnt.
24. FUNERAL DIRECTOR: Wm. J. Tiekner & sons
ADDRESS: Balto 17, Md.

MARGIN RESERVED FOR BINDING

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully

The

08145

08142 21

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 21

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Anne Arundel Co.

(a) ~~Baltimore~~ City, Maryland

Hanover P.O. Stoney Run Road

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in ~~Baltimore~~ (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town Hanover P.O. (If outside city or town limits, write RURAL and give town)

(d) Street No. Stoney Run Road (If rural give location)

(e) If foreign born, how long in U. S. A.? ...... years

3 (a) FULL NAME [illegible]

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife OLEM

6 (c) If alive, give age ...... years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day
72			...... hr. ...... min.

9. Birthplace Harford [illegible] (Town, county, and state)

10. Usual Occupation [illegible]

11. Industry or business

FATHER 12. Name John Wa[illegible] Phelps

13. Birthplace Maryland

MOTHER 14. Maiden Name Josephine Ritchie

15. Birthplace Virginia

16 (a) Informant Lillian E. Knight

(b) Address 2216 Berlin St. Balto 30

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15 1954 (month) (day) (year)

(c) Cemetery or crematory Friendship Cem.

Location Anne Arundel County

18 (a) Funeral director G. Truman Schuch

(b) Address 3512 Frederick Ave.

19 (a) Sep 15 1954 (Date rec'd by registrar) H. W. Vedrani Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1954, at 9 40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1952 to Sept. 1954, and that I last saw her alive on Sept. 10 1954.

Immediate cause of death Metastatic carcinoma

Due to secondary to carcinoma of the

Due to ~~uterine~~ cervix

Duration: 6 Years

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Karl F. Mech M.D. M. D.

Address 11 E. Chase St Balto-2, Md Date signed 9/13/54

08146

08143

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

1. PLACE OF DEATH:
COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hillsmere
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A. A.
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 400 Jefferson

3. NAME OF DECEASED: (Type or Print) (First) Oliver (Middle) B. (Last) Smith
4. DATE OF DEATH (Month) 9 (Day) 25 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Feby 20th 1930
9. AGE last birthday: 24 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Estimator
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stanley D. Smith
14. MOTHER'S MAIDEN NAME: Mary A. Issac

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of service) U.S.A. Force
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: Stanley D. Smith Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) DUE TO Carbon Monoxide — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Street.
21c. (City or town) (County) A.A.Co (State) MD
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY ~~9 25 54~~ M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR? Fourn in auto

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 9/27/54

23. BURIAL, CREMATION, REMOVAL (Specify): DATE THEREOF 9-28-54 NAME OF CEMETERY OR CREMATORY Hillcrest LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Sept. 27, 1954 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Sons ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08144

08147 **CERTIFICATE OF DEATH** Reg. Dist. No. 14

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 8 yrs. 3½ mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 1405 E. Eager St. ~~Unknown~~

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) Josephine Snipes

4. DATE OF DEATH: (Month) 9 (Day) 18 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH: Jan- 22-1912
9. AGE last birthday 42 — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic ~~Unknown~~
10B. KIND OF BUSINESS OR INDUSTRY Home ~~Unknown~~
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Vince Mitchell
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No ~~Unk.~~ (If Yes, give war or dates of service) ~~Unk.~~ No
16. SOCIAL SECURITY NO. ~~Unk.~~ None
17. INFORMANT & ADDRESS. Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Pericardial Tamponade — 10 minutes

ANTECEDENT CAUSE (S) DUE TO (B) Aortic Aneurysm — Known to us since adm. 6/1/46

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertensive Cardio-valvular Disease — Known to us since 6/1/46

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/6, 1952, to 9/18, 1954, that I last saw the deceased alive on 9/18, 1954, and that death occurred at 7:20p.M, from the causes and on the date stated above.

SIGNATURE Stephen E. Kramer M.D. ADDRESS Crownsville, Md. DATE SIGNED 8/20/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 9-23-54 — NAME OF CEMETERY OR CREMATORY Mt Calvary — LOCATION (City, town, or county) Brooklyn Md (State)

DATE REC'D BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR Elroy O. Wilson — ADDRESS 1000 Brantley Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08145

08148 # CERTIFICATE OF DEATH Reg. Dist. No. 27

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade
LENGTH OF STAY (in this place) unknown
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) unknown

3. NAME OF DECEASED: (Type or Print) (First) Edna (Middle) Raliegh (Last) Staples

4. DATE OF DEATH. (Month) September (Day) 10 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 25 December 1881

9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Esley Raliegh

14. MOTHER'S MAIDEN NAME: Kate Bromwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) -

16. SOCIAL SECURITY NO. -

17. INFORMANT & ADDRESS: Hosp. Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Lung infarct — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSE (S) DUE TO (A) Nephrosclerosis with uremia — unknown

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST DUE TO (B) Arteriosclerosis, general — unknown

(C) arteriosclerotic heart disease with heart block — 15 yrs

(C) Diabetes mellitus

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: -

19B. MAJOR FINDINGS OF OPERATION -

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work [ ] Not while at work [ ]

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3 Sept, 1954, to 10 Sept, 1954 that I last saw the deceased alive on 10 Sept, 1954, and that death occurred at 11:10 P.M., from the causes and on the date stated above.

SIGNATURE Theobald Reich — ADDRESS Theobald Reich, 1/Lt M.D. M.C. Fort Meade, Maryland — DATE SIGNED 10 Sept., 1954

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF unknown — NAME OF CEMETERY OR CREMATORY Stuart, Virginia — LOCATION (City, town, or county) (State) Stuart Virginia

DATE REC'D BY LOCAL REGISTRAR 13 Sept. 54 — REGISTRAR'S SIGNATURE E. A. GORDON CWO USA

24. FUNERAL DIRECTOR Franklin Byers — ADDRESS Baltimore, Maryland

VS. A15—10-

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 20
BUREAU V. S.

76

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08146

CERTIFICATE OF DEATH

08149

Reg. Dist. No. 23

(M)

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights
LENGTH OF STAY (in this place) 1 day.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 208 S. Camp Meade Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE New York COUNTY Green
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Athens
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Frederick (Last) Suess

4. DATE OF DEATH: (Month) September (Day) 1 (Year) 1954.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: March 20, 1901
9. AGE last birthday: 53 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor
10b. KIND OF BUSINESS OR INDUSTRY: Home Builder
11. BIRTHPLACE (State or foreign country): New York, N.Y.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Frederick William Suess
14. MOTHER'S MAIDEN NAME: Minnie Weeman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: 134 09-9162
17. INFORMANT & ADDRESS: Hazel Dora Suess [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1954, to Sept 1, 1954, that I last saw the deceased alive on Sept 1, 1954, and that death occurred at 8:30 P m., from the causes and on the date stated above.
SIGNATURE C. Milton Linthicum (DEGREE OR TITLE) M.D. ADDRESS Linthicum Hgts, Md. DATE SIGNED Sept 1, 1954

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
DATE THEREOF Sept. 6, 1954
NAME OF CEMETERY OR CREMATORY GLEN HAVEN CEMETERY
LOCATION (City, town, or county) (State) GLEN BURNIE, MD.

DATE REC'D BY LOCAL REG. September 3, 1954
REGISTRAR'S SIGNATURE Caldwell Woodruff L. J. D'Alba Sub.
24. FUNERAL DIRECTOR HOPPING & KIRKLEY James L. Kirkley ADDRESS GLEN BURNIE, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I)

VS. A15 8-5

SEP 7 1...
...AU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08147

08115 **CERTIFICATE OF DEATH** Reg. Dist. No. 21

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 -

1. PLACE OF DEATH:
COUNTY AA MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
LENGTH OF STAY (in this place) 61 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS USNH, Annapolis, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md.
STREET ADDRESS (If rural give location) 137 West

3. NAME OF DECEASED: (Type or Print) (First) Lucretia (Middle) Ann (Last) SUMNER

4. DATE OF DEATH: (Month) Sept. (Day) 27 (Year) 1954

5. SEX F

6. COLOR OR RACE: N

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): W

8. DATE OF BIRTH: 7-23-57

9. AGE last birthday 97 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): N.Y.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Willian H. Appleby

14. MOTHER'S MAIDEN NAME: May New

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) ---- ---

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS. USNH Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Carcinoma Generalized, nec #199

ANTECEDENT CAUSE (B) DUE TO Lower bowel.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-15, 1954, to 9-27-54, 19.., that I last saw the deceased alive on 9-27-54, 19.., and that death occurred at 0900 A M, from the causes and on the date stated above.

SIGNATURE AND ADDRESS M.D. D.S. Marcy U.S. Naval Hospital, Annapolis, Md. DATE SIGNED 9-27-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF 10/1/1954 NAME OF CEMETERY OR CREMATORY U.S. Naval Academy Cemetery LOCATION (City, town, or county) (State) Annapolis, A.A.Co. Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 28, 1954 REGISTRAR'S SIGNATURE H. C. Council

24. FUNERAL DIRECTOR AND ADDRESS Ethel L. Hicks—43-45 Northwest St, Annapolis, Md.

RECEIVED
SEP
BUREAU V. S.

08148

MARYLAND 08116

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

(M)

4.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS 133 Archwood Ave (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) JACOB (Middle) (Last) SWERBILOW (Lowe)

4. DATE OF DEATH (Month) SEPTEMBER (Day) 23 (Year) 1954

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH August 25, 1896

9. AGE last birthday 58 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President

10b. KIND OF BUSINESS OR INDUSTRY Retail Clothing Store

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Louis Swerbilow

14. MOTHER'S MAIDEN NAME Hanna Polakoff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) WW I

16. SOCIAL SECURITY NO 214-05-1165

17. INFORMANT AND ADDRESS Mrs. Ray Swerbilow * Wife* Same as # 2.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Anterior Myocardial Infarct [illegible]

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Uremia - Hypertrophy of single kidney

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

(1)

22. I hereby certify that I attended the deceased from 1 , 1953, to 4/2 31, 1954, that I last saw the deceased alive on 4/2 31, 1954, and that death occurred at 10 30/2 m., from the causes and on the date stated above.

SIGNATURE Sra L M Shipley (Degree or title) M.D. ADDRESS Annapolis DATE SIGNED 4/24/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Sept 24, 54

NAME OF CEMETERY OR CREMATORY Kenesith Israel Cemetery

LOCATION (City, town, or county) (State) Annapolis, Maryland

DATE REC'D BY LOCAL REG. Sept. 24, 1954

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Ben L. Hopping and Son ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08149

05150

Item9, FilmG170 9-17-54 et

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
LENGTH OF STAY (in this place): 22 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): 46 Hutton Place

3. NAME OF DECEASED (Type or Print): (First) Amos (Middle) (Last) Wallace

4. DATE OF DEATH. (Month) 9 (Day) 6 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 12-23-1898 AGE last birthday 55 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10B. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Nancy Wallace

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 219-03-5211A

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Severe myocardial damage DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/15, 1954 to 9/6, 1954, that I last saw the deceased alive on 9/6, 1954, and that death occurred at 4:15p M, from the causes and on the date stated above.

SIGNATURE: [signature] M. D.
ADDRESS: Crownsville, Md.
DATE SIGNED: 9/7/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: 9-10-54
NAME OF CEMETERY OR CREMATORY: Brewer Hill
LOCATION (City, town, or county) (State): Annapolis Md.

DATE REC'D BY LOCAL REGISTRAR: 9-8-54
REGISTRAR'S SIGNATURE: A. W. Hedrick
24. FUNERAL DIRECTOR: William Reece
ADDRESS: Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08151A8

08151 **CERTIFICATE OF DEATH** Reg. Dist. No. 181

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 2 yrs. 5½ mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 109 Madison Avenue

3. NAME OF DECEASED: (Type or Print) (First) Georgia (Middle) A. (Last) Washington
4. DATE OF DEATH: (Month) 9 (Day) 15 (Year) 1954

5. SEX: F
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 10/22/1895
9. AGE last birthday: 58 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Lloyd Washington
14. MOTHER'S MAIDEN NAME: Jennie Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1 month

ANTECEDENT CAUSE (S) DUE TO (B) generalized arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: ----
19B. MAJOR FINDINGS OF OPERATION: ----
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ----

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) ---- M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from 8/9, 1954 to 9/15, 1954 that I last saw the deceased alive on 9/15, 1954, and that death occurred at 9:10 a.m. from the causes and on the date stated above.

SIGNATURE [signature] ADDRESS Crownsville, Md. DATE SIGNED 9/15/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Sept 18-1954
NAME OF CEMETERY OR CREMATORY: Union Methodist
LOCATION (City, town, or county) (State): Aberdeen Maryland

DATE REC'D BY LOCAL REGISTRAR: Sept 18-54
REGISTRAR'S SIGNATURE: Hellie R. Ferry, Katherine M. Joyce
24. FUNERAL DIRECTOR: John E. Farring
ADDRESS: Aberdeen Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 5

RECEIVED
SEP 21
BUREAU V. C

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08151

08152

CERTIFICATE OF DEATH

Reg. Dist. No. 27

Item 2, FilmG172 10-25-54 et

1 PLACE OF DEATH:
COUNTY Anarundal MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS District Training School

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel Maryland
STREET ADDRESS (If rural give location) 1534 "E" St., S.E., Wash., D.C.

3. NAME OF DECEASED: (Type or Print) (First) Anthony (Middle) Louis (Last) Williams

4. DATE OF DEATH: (Month) Sept (Day) 29 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 7-4-51
9. AGE last birthday: 3 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Wilbert Williams
14. MOTHER'S MAIDEN NAME: Mary Bonham

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: —
17. INFORMANT & ADDRESS: Chart

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Inanition
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Spastic Paralysis - Microcephalic
DUE TO
(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Birth Injury

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 6-26, 1953, to 9-29, 1954 that I last saw the deceased alive on 9-29, 1954, and that death occurred at 11:25 AM, from the causes and on the date stated above.

SIGNATURE Dwitt Tichnodge (Degree or title) MD.
ADDRESS Laurel - Maryland
DATE SIGNED 9-29-54

23. BURIAL, CREMATION, REMOVAL (Specify) Removal
DATE THEREOF Sept 2-54
NAME OF CEMETERY OR CREMATORY Woodlawn
LOCATION (City, town, or county) (State) Dist of Columbia

DATE REC'D BY LOCAL REGISTRAR Sept 30-54
REGISTRAR'S SIGNATURE Clara Bashop
24. FUNERAL DIRECTOR R. L. Crouch 51 K St nw Wash. DC
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS. A15

08152

MARYLAND 08117

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH — COUNTY: ANNE ARUNDEL — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS, MD.
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: A. A. GENERAL HOSP.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: MD. — COUNTY: A. A. Co.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS, MD.
STREET ADDRESS (If rural, give location): 138 CONDUIT ST.

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) N. (Last) WILSON

4. DATE OF DEATH: (Month) 9 (Day) 23 (Year) 1954

5. SEX: M
6. COLOR OR RACE: W
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify)
8. DATE OF BIRTH: 6/15/1890
9. AGE last birthday: 64 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ATHLETIC COACH
10b. KIND OF BUSINESS OR INDUSTRY: Athletics
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Scott K. Wilson
14. MOTHER'S MAIDEN NAME: CORA NICODEMUS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: MRS J. N. Wilson (2)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) with Left Hemiplegia

(c) Hypertensive vascular disease — 4 years

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis [illegible] — 3 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-21, 1954, to 9-23, 1954, that I last saw the deceased alive on 9-23, 1954, and that death occurred at 11:30 p.m., from the causes and on the date stated above.

SIGNATURE: George C. Basil (Degree or title) M.D. — ADDRESS: Annapolis Md — DATE SIGNED: 9-25-54

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) — DATE: 9/26/54 — NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF — LOCATION (City, town, or county): ANNAPOLIS (State): MD.

DATE REC'D BY LOCAL REG.: Sept. 26, 1954 — REGISTRAR'S SIGNATURE: [illegible] — 24. FUNERAL DIRECTOR: JOHN M. TAYLOR + SONS — ADDRESS: ANNAPOLIS MD

08118

08153 Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY: Anne Arundel Co. | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel Gen. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Balto.
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Stoneleigh
STREET ADDRESS (If rural, give location): 7107 Wardman Rd.

3. NAME OF DECEASED (Type or Print): (First) EMMA (Middle) H. (Last) WRIGHTSON

4. DATE OF DEATH: (Month) 9 (Day) 26 (Year) 1954

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Nov. 21, 1897

9. AGE Last birthday: 56 yrs. | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Hofmann

14. MOTHER'S MAIDEN NAME: Emma ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no | (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: no

17. INFORMANT & ADDRESS: Mr. Frank W. Wrightson - 7107 Wardman Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Drowning — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) — DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: Sudden

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) AA (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 9/26/54

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation

DATE THEREOF 9/29/54

NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.

LOCATION (City, town, or county) (State): Balto., Md.

DATE REC'D BY LOCAL REG. 9-27-54

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: Wm. J. Tideney & Sons

ADDRESS: Balto 17, Md.

Newspaper report: Fell from Pier at the South River Yacht Club.

MARYLAND 08119

08154

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis 10
STREET ADDRESS (If rural, give location) 1209 West St.

3. NAME OF DECEASED (Type or Print) (First) ESTHER (Middle) ZIFF (Last)

4. DATE OF DEATH (Month) SEPTEMBER (Day) 24, (Year) 19 54

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Dec. 22, 1892

9. AGE Last birthday 61 yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10b. KIND OF BUSINESS OR INDUSTRY own home X

11. BIRTHPLACE (State or foreign country) England

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jacob Valinsky

14. MOTHER'S MAIDEN NAME Hanna Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) no

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Mr. Joseph Ziff- Husband- same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Massive Pulmonary Embolism — Interval between onset and death: minutes

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Thrombophlebitis

(c) Venous ligation for varicose vein & orthopedic operation on foot — 7 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes XX No ☐

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/24/, 19 54, to 9/24/, 19 54, that I last saw the deceased alive on 9/24/54, 19, and that death occurred at 9:50 a.m., from the causes and on the date stated above.

SIGNATURE Frank M. Quigley (Degree or title) M.D. ADDRESS Annapolis DATE SIGNED 9/24/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Sept. 26 '54

NAME OF CEMETERY OR CREMATORY Kenesith Israel Cemetery

LOCATION (City, town, or county) (State) Annapolis, Maryland

DATE REC'D BY LOCAL REG. Sept. 25, 1954

REGISTRAR'S SIGNATURE J. O. Council

24. FUNERAL DIRECTOR Ben L. Hopping and Son ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 28 1954
BUREAU V. S.